

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049276

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12834

FILED JAN 6 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 4236 Castleman Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD(BEN) BOWLDS		4. DATE OF DEATH Month Day Year Dec. 25 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man-Frisco Hospital		11. BIRTHPLACE (City and state or country) Fairfield, Ill.	
13a. FATHER'S NAME Unknown Bowlds		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Lula Mae Morgan 4236 Castleman Ave.		14. NAME OF HUSBAND OR WIFE Late Camille Bowlds	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis DUE TO (b) 587.0 DUE TO (c) 587.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ANTERIOR MYOCARDIAL INFARCTION - PEPTIC ULCER.		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from July, 1956, to Death, and last saw him alive on Dec. 25th. Death occurred at 2:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Paul M. Larson M.D.		22b. ADDRESS 3654 South Grand	
22c. DATE SIGNED 12/26/63		23. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 27, 1963	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. DEC 26 1963	
26. REGISTRAR'S SIGNATURE Loal Smith M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. Storrison

Licensed Embalmer No. 4007

P. O. Address St. Louis mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.